favorable experimentally, but this may have been due to the fact that the material was not continuously in contact with the denuded area.

Eosinophiles in the Urine in Bronchial Asthma.—A. EDELMANN and L. KARPEL (*Deutsch. med. Woch.*, 1912, xxxviii, 1271) report their study of the urine of 4 patients suffering with bronchial asthma. In all of the patients there was noticed a slight cloudiness of the urine following the attacks of asthma, so that a cystitis was suspected at first, though there were no symptoms to suggest such a condition. The fresh specimen of sediment showed many leukocytes. Stained preparations revealed an eosinophilia of as much as 30 per cent. Careful examinations then showed that eosinophiles were always abundant in the urine following the asthmatic paroxysm. In none of the patients were there symptoms referable to the genito-urinary tract, and no epithelial cells or bacteria were found in the urine. There was no gonorrheal infection. The urinary changes consisted in the appearance of leukocytes alone; no other formed elements, such as casts or red blood cells, were found. The number of leukocytes resembled that seen in cystitis. There was no albuminuria. The cells make their appearance in the urine, as stated above, just after the paroxysm; during the dyspneic period the urine is clear or contains only an occasional leukocyte. The cells persist in the urine from a few hours to two days. Differential count of the cells of the urinary sediment showed 30 per cent. of eosinophiles in a patient whose blood contained only 8.5 per cent. of these cells. Edelmann and Karpel describe their methods of staining the cells of the sediment.

Lymphocytosis in Diabetes Mellitus.—L. CARO (*Berlin. klin. Woch.*, 1912, xlix, 1514), who called attention to the lymphocytosis of Basedow's disease in 1907, now reports the examination of the blood of 28 diabetics—a phase of the disease which has apparently been neglected heretofore. Practically all cases showed a reduction in the number of erythrocytes and in percentage of hemoglobin. The leukocytes were normal in number. Of the 28 cases, 22 exhibited a marked lymphocytosis; in 15 of the cases the lymphocytes varied between 40 and 70 per cent., while 7 cases showed less than 40 per cent. Only 6 patients had a normal percentage of lymphocytes (or a slight increase), but in these there were complications, such as suppuration, gangrene, tuberculosis, bronchiectasis. In 8 instances the eosinophiles were increased (up to 500 cells per cmm.). The lymphocytosis is independent of the severity of the disease and of the sugar content of the urine. No interpretation of the lymphocytosis is attempted. The thyroid gland is apparently not concerned in its production.

The Diagnostic Value of the Coin Sound in Pleuritic Effusions.—B. M. SLATOWERCHOWNIKOW (*Deutsch. med. Woch.*, 1912, xxxviii, 1282) has studied the *signe du sou*, described by Pitres in 1898, in 48 cases, 28 of which were exudative pleuritis. He finds that the most satisfactory method of eliciting the phenomenon is to have an assistant tap with one coin upon another which is placed over the dull area.

while the examiner auscultates the opposite side of the chest. If spongy or alveolar tissue intervenes between the points of percussion and auscultation, a dull tone without metallic quality is heard. With an air space (pneumothorax) the tone is, of course, intensely metallic. If a solid tissue or fluid is interposed between the points of percussion and auscultation, the sound is transmitted with an appreciable metallic quality. Heterogeneous tissue, as alveolar tissue and fluid, causes the sound to be simply dull. It is evident, therefore, that the distribution of the metallic sound in pleural effusion should correspond with the areas of dulness and diminished vocal fremitus. Slatowerchownikow finds, however, that the *signe du sou* extends 1 to 1.5 cm. beyond the lines marked out by percussion and vocal fremitus. With the exploratory needle he was able to demonstrate that fluid extended to the line given by the coin sound. He finds this method of examination very helpful in patients with weak voice. It is doubtless because of the difficulty of examining vocal fremitus in children that Pitres' observations have found their widest acceptance among pediatricians.

The Pathogenesis of Purpura Hæmorrhagica with Especial Reference to the Part Played by the Blood-platelets.—Duke (*Arch. Int. Med.*, 1912, x, 445) reëmphasizes the fact that in studying the various hemorrhagic diseases one must investigate all the various factors involved—bleeding time, coagulation time, platelet count, fibrinogen content, etc. The particular group of cases under consideration present a characteristic clinical picture: Purpura (petechia or ecchymoses), a tendency to bleed from every vascular lesion no matter how produced (prolonged bleeding time), normal coagulation time, a firm blood clot, and a clot which does not retract and exude serum. In milder cases the same essential condition may manifest itself only by ecchymosis, following slight injury, epistaxis, or hemorrhage due to local cause such as intestinal ulcers, esophageal varices, or profuse and prolonged menstruation. Coagulation time is always normal, the clot firm, retractility diminished. These conditions Duke believes to be due wholly or in part to the enormous reduction in the number of blood platelets which he found invariably present. In 7 severe cases showing the picture described above the number of platelets was reduced almost to the point of absence, all the counts being below 10,000, and as a rule below 1000 (normal, 200,000 to 400,000). In 6 milder cases they varied from 20,000 to 65,000. It was observed that the symptoms of the disease ran a course roughly parallel to the number of platelets, appearing when they fell to a very low level, and disappearing when the count rose. Furthermore, in 2 cases there was immediate relief following direct blood transfusion, and the relief being coincident with the increase in platelets following the transfusions. In both the clinical cases and in animals in which the platelet count was changed with subcutaneous injections of benzol, diphtheria toxin, and tuberculin, it was found that extreme symptoms of purpura hæmorrhagica only appeared when there were very low counts. Several counts of 40,000 to 75,000 were observed in patients who had no marked tendency to bleed, but no counts lower than these were observed in patients not subject to hemorrhage. Finally Duke points